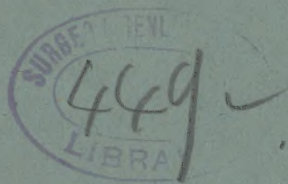


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LACERATION OF THE CERVIX.

BY
H. J. GARRIGUES, M.D.,
New York.



[Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES
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THE IMMEDIATE CLOSURE OF LACERATION OF THE CERVIX.

ARTERIAL hemorrhage from the cervix is a rare occurrence, but sometimes it will occur, and is then a serious thing. A few months ago I had such a case, in which the patient came very near losing her life. There had also been a laceration of the perineum due to the large size of the child. This I united with three sutures, and it took some time before I realized that there was a source of hemorrhage above the united perineum. Loath to sacrifice the work just done, I tried first hot-water injections, and then styptic injections with diluted liquor ferri chloridi; but the bright-red blood continued to flow in a little steady stream, and it became necessary to sacrifice the perineum and apply a tampon.

When such an accident happens in a hospital it is a small matter to lay the patient in Sims' position, introduce his speculum, and unite the torn cervix with silver wire. It is easily done, it is safe, and is a sure cure. But in private practice it is not always feasible, and then tamponade may be of the greatest value; but to be effectual the vagina should literally be packed full with cotton wrung out of a one-per-cent solution of creolin. The tampon must extend through the whole vulva out to the lower edge of the labia majora, and then a piece of muslin should be pinned very tightly to the binder in front and behind, so as to combine pressure from without with that against the vaginal wall and the styptic effect of the creolin.

The immediate closure of the lacerated cervix with silver-wire sutures was practised and recommended by the late Dr. Pallen¹ in 1874.

There is no danger that the suture will cut through. On the contrary, the cervix becoming smaller every day after the birth of the child, the sutures will rather become loose, but before that happens union will have taken place.

In my opinion hemorrhage due to the laceration should be the only indication for the immediate closure. I am convinced from personal experience that many lacerations heal spontaneously, so that an operation would be superfluous.

Furthermore, the immediate closure of the lacerated cervix exposes the woman to infection. My rule is, if it can be avoided, never to introduce as much as a finger into the parturient canal after the birth of the child. The placenta is expressed by Credé's method. After the expulsion of the child the parturient canal is full of wounds and abrasions, and there is a strong current of blood and lymph toward the interior of the body. At no time is the susceptibility for infection greater.

In this respect there is a fundamental difference between the immediate perineorrhaphy and the immediate trachelorrhaphy. The former is an important prophylaxis against infection. By disinfecting the torn surface and uniting it we exclude a large area through which infection might take place, and the operation is performed in such a way that the deeper parts are not touched at all, and are even protected with a temporary antiseptic tampon above the torn part. In order to perform trachelorrhaphy we are, on the contrary, obliged to bring the cervix into view and to give the air—which, in my opinion, is often the carrier of the microbes that cause puerperal infection—access to the uterus.

But if there is hemorrhage that resists hot water and styptics, it must be checked, and, performed with proper antiseptic precautions, I hold the primary trachelorrhaphy to be preferable to the tamponade. If the necessary instruments were not at hand, I would even prefer the application of one or two of Koeberle's *serre-fines* to the tampon, since it would not interfere with the free flow of the lochial discharge.

¹ AMERICAN JOURNAL OF OBSTETRICS, 1879, vol. xii., page 322.

